Orthopedic Initial Questionnaire

CORVALLIS & ALBANY SPORT & SPINE PHYSICAL THERAPY

Name: ______________________________ Height: ________________________

Date: ______________________________ Weight: ________________________

In order to allow the therapist to have a better understanding of the nature of your injury and evaluate your condition fully, please complete the following questions as accurately as possible. Thank you.

1. When did your symptoms start (date)? ____________________
2. Briefly describe how your symptoms began or how your injury occurred. __________________________________

   ____
3. Date of first doctor's appointment for this injury or for these symptoms. ______________________
4. Have you had surgery for this injury? ❑ Yes ❑No If yes, when? ______________________
5. The onset of my symptoms was ❑ Gradual ❑ Sudden
6. What are your symptoms (i.e., pain, numbness, tingling)?

   ____
7. What is your worst pain (0-10)? ________
8. What is your current pain (0-10)? ________
9. What is your best pain (0-10)? ________
10. Type of pain?

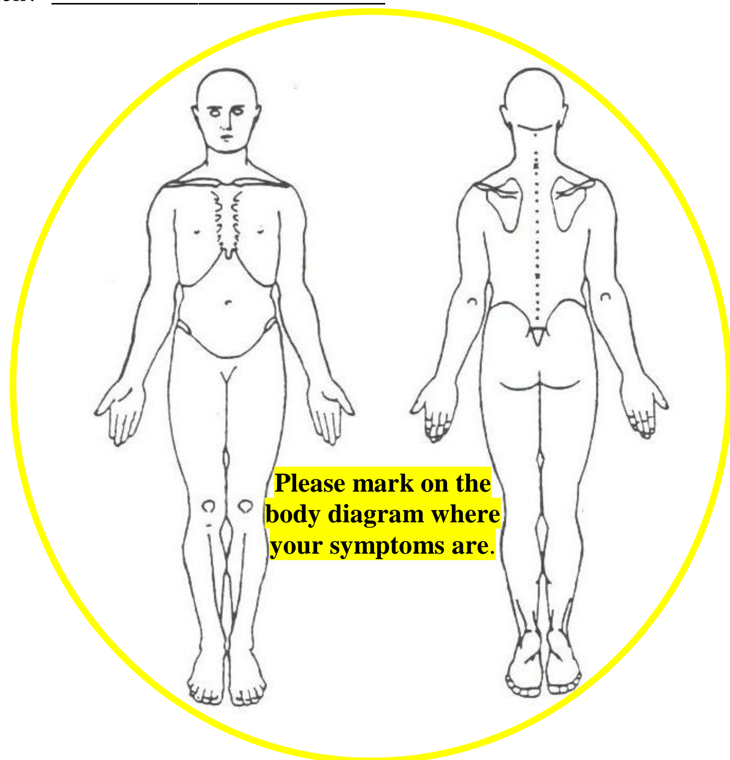
    ❑ Sharp ❑ Dull ❑ Throb ❑ Ache ❑ Burning
11. My symptoms have

    ❑ worsened ❑ remained the same ❑ improved
12. My symptoms bother me

    ❑ constantly ❑ most of the time ❑ occasionally
13. What makes your symptoms worse? ____________________

    ____
14. What makes your symptoms better? ____________________

    ____



15. Since the onset of this injury, have your noticed any of the following:
    a. Regular numbness or tingling? ❑ Yes ❑ No If yes, where? ____________________________
    b. Bowel/bladder control difficulties? ❑ Yes ❑ No
16. Have you had any imaging of your injury? ❑ Yes ❑ No If yes, when did you have your imaging? ___________

    ❑ Xray ❑ MRI ❑ Bone Scan ❑ CT Scan ❑ Ultrasound
17. What were the results? ____
18. Have you had this pain or problem before? ❑ Yes ❑ No

    If yes,
    a. Did you receive any treatment? ❑ Yes ❑ No If yes, did the treatment help? ❑ Yes ❑ No
    b. What did the treatment consist of? ____

19. What are your goals for physical therapy? ____

____

20. Rate on a scale of 0 to 10 (0 being unable to perform) 3 activities you are having difficulty doing as a result of your injury/pain?

____

____

____

21. On a scale from 1-10, How would you rate your overall health? (1= poor, 10= excellent)______________________

22. What do you do for recreation/exercise? ____

23. Is there anything else about you or your condition that you would like us to know? ______________________

____

Medical History

Allergies	❑Yes	❑No	Dizzy Spells	❑Yes	❑No	MRSA	❑Yes	❑No
Anemia	❑Yes	❑No	Emphysema/Bronchitis	❑Yes	❑No	Multiple Sclerosis	❑Yes	❑No
Anxiety	❑Yes	❑No	Fibromyalgia	❑Yes	❑No	Muscular Disease	❑Yes	❑No
Arthritis	❑Yes	❑No	Fractures	❑Yes	❑No	Osteoporosis	❑Yes	❑No
Asthma	❑Yes	❑No	Gallbladder Problems	❑Yes	❑No	Parkinson's	❑Yes	❑No
Autoimmune Disorder	❑Yes	❑No	Headaches	❑Yes	❑No	Rheumatoid Arthritis	❑Yes	❑No
Cancer	❑Yes	❑No	Hearing Impairment	❑Yes	❑No	Seizures	❑Yes	❑No
Cardiac Conditions	❑Yes	❑No	Hepatitis	❑Yes	❑No	Smoking	❑Yes	❑No
Cardiac Pacemaker	❑Yes	❑No	High Cholesterol	❑Yes	❑No	Speech Problems	❑Yes	❑No
Chemical Dependency	❑Yes	❑No	High/Low Blood Pressure	❑Yes	❑No	Strokes	❑Yes	❑No
Circulation Problems	❑Yes	❑No	HIV/AIDS	❑Yes	❑No	Thyroid Disease	❑Yes	❑No
Currently Pregnant	❑Yes	❑No	Incontinence	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Depression	❑Yes	❑No	Kidney Problems	❑Yes	❑No	Vision Problems	❑Yes	❑No
Diabetes	❑Yes	❑No	Metal Implants	❑Yes	❑No	Other		

Have you **recently** noticed any of the following?

WEIGHT GAIN/LOSS	❑Y	❑N	FATIGUE	❑Y	❑N	DIZZINESS	❑Y	❑N
NAUSEA/VOMITING	❑Y	❑N	WEAKNESS	❑Y	❑N	FEVER/CHILLS/SWEATS	❑Y	❑N
NIGHT PAIN	❑Y	❑N						

Fall History

Is this injury as a result of a fall in the past year? ❑Yes ❑No Have you had two or more falls in the past year? ❑Yes ❑No

If yes to either, please explain: ____

____

Surgical History

Body Region: ______________ Surgery Type: ______________________Date: _____/_____/_____

Body Region: ______________ Surgery Type: ______________________Date: _____/_____/_____

Body Region: ______________ Surgery Type: ______________________Date: _____/_____/_____

Current Medications: Please provide a copy of your entire medication list

Drug: __________ Dosage: _____ Frequency: ______ Route: ______ Reason for Taking: __________

Drug: __________ Dosage: _____ Frequency: ______ Route: ______ Reason for Taking: __________

Drug: __________ Dosage: _____ Frequency: ______ Route: ______ Reason for Taking: __________

ASSIGNMENT OF BENEFIT, CONSENT FOR TREATMENT, AND RELEASE OF INFORMATION

I, the undersigned, assign directly to Corvallis & Albany Sport and Spine Physical Therapy, Inc. all medical benefit, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are reimbursed by my insurance company. I hereby authorize Corvallis & Albany Sport and Spine Physical Therapy, Inc. to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third party and that I may contact them with questions regarding my account.

I, the undersigned, voluntarily consent to physical therapy services at Corvallis & Albany Sport and Spine Physical Therapy, Inc. as ordered by my Physician and/or Therapist. I authorize Corvallis & Albany Sport and Spine Physical Therapy, Inc. to release my physical therapy records to my physician listed below.

Primary Care Physician Name: ____

Referring Doctor Name: ____

Patient Signature (or Guardian): ______________________________ Date: __________

CORVALLIS & ALBANY
SPORT & SPINE
PHYSICAL THERAPY

Corvallis
2635 NW Rolling Green Drive, Corvallis, OR 97330
Phone: 541-752-0545 FAX: 541-757-0545

Albany
617 Hickory Street NW, Suite 160, Albany, OR 97321
Phone: 541-928-1411 FAX: 541-928-7044

Patient Information

Last Name First Name MI DOB Sex

Mailing Address City State Zip

Marital Status Occupation Employer

Email — Would you like appointment reminders by email? ❑Y ❑N

Home Phone — Primary? ❑Y ❑N — Would you like appointment reminders by voice calls? ❑Y ❑N

Cell Phone — Primary? ❑Y ❑N — Would you like appointment reminders by text message? ❑Y ❑N

Work Phone — Primary? ❑Y ❑N

Emergency Contact Relationship Phone

May we leave a voicemail on your primary contact voicemail/answering machine if necessary? ❑Y ❑N

Who should receive statement *after* insurance is billed? ______________________________

(**If not you**, please check all that apply to responsible party) ❑Guarantor ❑Spouse ❑Parent

Name Relationship Contact #

DOB Billing Address (if different from patient's)

Would you like to receive the CSSPT/ASSPT Quarterly Newsletter via email from E-Rehab? ❑Y ❑N

How did you hear about Corvallis/Albany Sport and Spine Physical Therapy? ______________________

Please fill out the following only if applicable:

Auto and On the Job Injury

Name of Insurance Carrier	Claim #	Date of Injury
Address		Adjuster Name
City, State Zip		Adjuster's #
Employer's Name and Address		Employer's #

OFFICE PAYMENT POLICIES

It is the policy of Corvallis & Albany Sport and Spine Physical Therapy that payment is due and to be made at the time service is rendered unless other financial arrangements are made in advance. Our physical therapy charges are consistent with other clinics in the area. If you are covered by health insurance with physical therapy benefits, we will gladly bill your insurance for you. You will be asked to provide this information to the office manager upon your first visit and we will verify your coverage as a courtesy.

It is your responsibility to familiarize yourself with your particular benefit package as you know your policy better than we do. Occasionally, there are discrepancies in what you and the insurance company understand your policy to entail. We base our billing on the information the insurance company provides us.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not automatically guarantee that your insurance will cover our services. **Please remember that you are 100% responsible for all charges incurred.** The physician referral and our verification of insurance benefit do not guarantee payment. Do not assume that you will not owe anything if you have more than one insurance policy. If you fail to give us your insurance information by your second visit, you will be billed for all charges.

Please initial that you have read and understand the following policies:

_______ **RETURNED CHECKS.** Returned checks will be charged a $45.00 fee.

_______ **BILLING INFORMATION.** Past due accounts (i.e., over 90 days) will be subject to a $10 re-billing fee. If no payment is received or your account is not made current, we will initiate collection procedures. Accounts sent to collections will be subject to a $100 billing fee. You will be responsible for all incurred fees related to the collection of your account including attorney, collection service, and court costs.

_______ **CANCELLATION AND NO-SHOW POLICY.** Should you not be able to make a previously scheduled appointment, a 24-hour notice of cancellation must be provided by phone, email or in person. **If notification of cancellation is not received 24 hours before the scheduled appointment, a $50 service charge will be billed directly to the patient for each cancellation. The $50 service charge will be assessed prior to receiving services at the next visit.** We at Corvallis Sport and Spine Physical Therapy want to provide the best possible care for our patients and attending your scheduled appointments is the necessary part of the treatment process. **Patients who fail to show up for multiple appointments will be assessed the $50 service charge and all appointments made in advance will be cancelled.** If this occurs, the patient will only be allowed to schedule one visit in advance. Each patient will receive one "free" no show or cancellation before being charged. If you must cancel due to sickness or medical/family emergency, you will not incur a charge.

Please initial next to your payment method (choose one) and sign that you have read, understand, and agree with all of the information in this policy.

_______ 1. **CASH PAY.** We will be happy to accept cash pay patients and you will receive a **discount** off our fees. **Payment is due at the time service is rendered** and you will receive a receipt. If you have insurance and we are not a preferred provider, you may pay by cash and may be reimbursed by your insurance company if allowed. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service.

_______ 2. **PRIVATE HEALTH INSURANCE.** Some insurance plans require authorization and/or a referral from your primary care physician. Most insurance companies have a deductible (i.e., amount paid by the patient before the insurance coverage begins) and either a co-pay (i.e, a set dollar amount per visit) or coinsurance (i.e., a percent of the allowed charges). **Deductibles, co-pays, and co-insurance payments are due at the time of service**. We will bill you for coinsurance or other balances due after we have been paid by your insurance company or notified of their denial for payment. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your insurance company.

_______ 3. **MEDICARE.** Corvallis Sport and Spine Physical Therapy, Inc. is a Medicare Preferred Provider. Medicare has an annual deductible of $147.00 for PT and Speech. Medi-Gap insurance covers the patient's portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your insurance company.

_______ 4. **WORKER'S COMPENSATION CLAIMS**. Authorization from your insurance adjuster is required before you can begin treatment. Please provide the name and number of your adjuster as well as your claim number, the date of injury and any other pertinent information. Remember, most worker's compensation carriers have up to 90 days to accept your claim. If they deny your claim, you are responsible for the balance. We will be happy to bill your personal health insurance company at that time. **If they deny your claim, you will be responsible for the entire balance.** Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your workers' compensation claim. Please sign a release of information authorization allowing us to discuss your treatment with your attorney. If you retain an attorney during or after your course of treatment, please inform the office manager of this change.

_______ 5. **THIRD PARTY PAYERS AND AUTO LIENS.** We will bill your insurance, however, third party payments will be sent to you for services we provide. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your insurance company. You are responsible for payment of all services provided. Be sure to contact the office when your case is settled to ensure your account has been paid. Please sign a release of information authorization allowing us to discuss your treatment with your attorney. If you retain an attorney during or after your course of treatment, please inform the office manager of this change.

I have reviewed this office policy statement and discussed it with the office manager or my therapist. All of my questions have been answered to my satisfaction and I understand all of the information as explained to me.

Patient Signature (or Guardian): ____ Date: _____________

Facility Review: _________ Date: _____________